Fall Risk Assessment/ Evaluación del riesgo de caídas

Patient Name/Nomber del Paciente: _____

Date/Fecha: _____

Have you had any falls in the last year? (Please check on*); Ha tenido alguna caída en el último año? (Por favor marque una opción)*
☐ No ☐ Yes/Si

If yes, how many falls? / *Si es así, cuántas caídas*? _____

Were you injured? / Se lesionó?
☐ No ☐ Yes

Describe any injury / *Describa cualquier lesión*:

_____

_____

_____

For Office Use Only

*Falls: Plan of care is required if there is documentation of two or more falls in the past year or any fall with injury in the past year.

Plan of Care must include: 1. Consideration of Vitamin D supplement **AND** 2. Balance, strength, and gait training.

☐ Vitamin D supplementation advised/considered
☐ Referral for Vitamin D consultation

AND

☐ Balance/strength/gait training provided
☐ Referral to exercise program
☐ Referral to physical therapy